Office of the State Employer
Employee Health Management

REQUEST FOR AT RISK ASSESSMENT

EHM referral #:

Referral Source: **Date:**

Department: **Phone:**

Employee's Name: **SSN:**

Work Address: **Disability:**

City/State/Zip Code: **County:**

Office Phone Number(s): **DOB:**

Last Day Worked: **Date of Injury:**

Classification: **Agency/Division**

Supervisor (include phone number):

Employment Location:

SERVICES REQUESTED:

- ☐ **Advanced/Comprehensive Ergonomic Assessment** (chair & work station/space assessment)
- ☐ **Ergonomic Assessment** (work station/space assessment)
- ☐ **Office/Task Chair Assessment** (chair evaluation)
- ☐ **Return-to-Work Evaluation** (ergonomic assessment to include job analysis following a LOA for an injury/illness)
- ☐ **Other:** _____

ADDITIONAL INFORMATION:

See attached medical

Return Request to:

Employee Health Management
P.O. Box 30026
400 S. Pine Street
Lansing, Michigan 48909
Phone: (517) 241-9090
Fax: (517) 335-7087
E-mail: BallingerB1@michigan.gov

FOR EMPLOYEE HEALTH MANAGEMENT USE ONLY:	
Date Received ____/____/____	**Request for Assessment is:** ☐ **Approved** ☐ **Denied**